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Physicians and Surgeons: Hospital Liability for Emergency Room Treatment: Is the Ostensible Agency Doctrine Viable in Oklahoma?

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Traditionally, emergency rooms treated only "true" emergencies involving accident victims, suicidal persons, victims of fires or other disasters, and persons suffering heart attacks.[1] Patients now look to hospital emergency facilities as outpatient and backup centers that provide convenient treatment of nonemergent illnesses as well as conditions requiring immediate care.[2] Those who come to hospital emergency rooms probably give no thought to whether treatment is given by agents/employees of the hospital or by staff physicians who are considered to be independent contractors. These patients most likely assume that all who work in the emergency room are agents of the hospital. In light of these expectations, courts have begun to apply the apparent or ostensible agency rule to create vicarious liability where it appears that the hospital is offering particular physician services.[3]

This note discusses the general expansion of hospital liability in the emergency room context through the application of the ostensible or apparent agency doctrine. The doctrine allows a hospital to be held vicariously liable for the negligence of independent contractor physicians and other medical personnel who staff emergency rooms. Courts will consider the following factors in determining whether an ostensible agency exists: (1) whether the emergency room patient had a preexisting relationship with the treating physician; (2) whether the physician was an independent contractor; (3) whether the patient, at the time of his admission to the hospital, looked primarily to the hospital for treatment; and (4) whether the patient reasonably relied on the hospital's representation that the treating physician was acting on behalf of the hospital.[4]

This note analyzes the decision of the Oklahoma Supreme Court in *Weldon v. Seminole Municipal Hospital*.[5] In *Weldon* the supreme court took

1. HOSPITAL LIABILITY LAW AND TACTICS 592 (M. Bertolet & L. Goldsmith eds. 4th ed. 1980) [hereinafter HOSPITAL LIABILITY LAW].

2. *Id.* For the purpose of this note, the term "hospital" means

> any institution, place, building or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care of patients admitted for overnight stay or longer in order to obtain medical care, surgical care, obstetrical care, or nursing care for illness, disease, injury, infirmity, or deformity.

See 63 OKLA. STAT. § 1-701 (1981). A physician is one who is licensed to treat disease or injury. 59 OKLA. STAT. § 492 (1981). *See also* 59 OKLA. STAT. § 725.2 (1981) (designating who can use the word "doctor").

3. *Principles of Hospital Liability*, in 2B HOSPITAL LAW MANUAL 1, 50 (P. Lasky ed. 1986) [hereinafter *Principles of Hospital Liability*].

4. *See, e.g.*, Grewe v. Mt. Clemens Gen. Hosp., 273 N.W.2d 429, 433 (Mich. 1978); Hardy v. Brantley, 471 So. 2d 358, 371 (Miss. 1985); Smith v. St. Francis Hosp., Inc., 676 P.2d 279, 282 (Okla. Ct. App. 1983); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970, 975 (1978).

5. 709 P.2d 1058 (Okla. 1985). The court recognized the doctrine of apparent agency as set out in Smith v. St. Francis Hosp., Inc., 676 P.2d 279 (Okla. Ct. App. 1983).

a restrictive view of the ostensible agency doctrine and refused to extend the liability of a hospital for the acts of emergency room physicians who were independent contractors. The critical factor on which the supreme court's decision turned was the preexisting relationship between the doctor and the patient who sought treatment from the hospital emergency room.

After careful consideration of the central issues, this note concludes that the Oklahoma Supreme Court should not impose restrictions that prevent the application of the ostensible agency doctrine. Even when the patient is treated by his own physician, there are still instances when a hospital should be liable for the physician's negligence. Certainly, when a patient looks to a hospital for treatment in reliance on the hospital's representation to the public that it does provide such care, courts should look to principles of agency in determining liability. Consideration of whether ostensible agency applies outside the emergency room context is beyond the scope of this note.

Emergency Care in General

Emergency Defined

A hospital emergency department typically has a high-pressure atmosphere that rarely allows time for leisurely diagnosis and consultation. The emergency physician is periodically stressed by a steady flow of patients, all of whom want immediate treatment and who bring with them varying numbers of emotionally strained family members and friends.[6]

The American Hospital Association (AHA) defines an emergency as any condition that requires immediate medical attention, whether in the opinion of the patient or whoever assumes the responsibility of bringing the patient to the hospital. A true emergency is one that has been clinically determined to require immediate medical care. A true emergency may be classified as emergent, a condition that is acute and potentially life threatening; or it may be classified as urgent, a condition that is acute but not necessarily severe. A condition that does not require the resources of an emergency service is classified as nonurgent.[7]

Statistics indicate that in 1984 the number of emergency room visits was approximately 160 million compared with 35,729,801 visits in 1968.[8] Reasons advanced for this marked increase in the use of emergency departments include: (1) the decrease in the number of general practitioners of medicine; (2) the around-the-clock availability of service provided by emergency rooms; and (3) the general public's perception of the emergency room as a neighborhood health center.[9]

A study of the reasons persons seek emergency care reveals that physicians and patients have differing concepts of emergency.[10] Complaints presented

6. J. GEORGE, LAW AND EMERGENCY CARE at *v*, (1980).
7. M. MANCINI & A. GALE, EMERGENCY CARE AND THE LAW 44-45 (1981).
8. *Id.* at 43.
9. *Id.*
10. HOSPITAL LIABILITY LAW, *supra* note 1, at 592.

by patients or their medical history have been classified as: poisoning, "dead on arrival," fractures, minor or major burns, abrasions, contusions, lacerations, respiratory infection, skin disease, and psychosomatic problems.[11] The variety and complexity of complaints coupled with the emotionally charged and stressful conditions under which medical help is provided demand that a hospital provide adequate service through its emergency staff to avoid liability for injuries to patients.

Emergency Departments and Their Responsibility to Treat

At common law, no duty exists to treat another in peril.[12] This doctrine has been applied to physicians and to hospitals as well as to lay persons.[13] Private hospitals may set their own admissions criteria on nondiscriminatory grounds.[14] However, obtaining federal assistance under the Hill-Burton Act requires that a certain volume of service be provided to persons unable to pay.[15]

Although the common law does not impose a duty upon a general hospital to provide treatment and care for emergency patients, a few states have statutory laws that either directly or indirectly require some hospitals to render emergency care.[16] These statutes are an apparent attempt to meet public expectations that every community should provide ready and convenient access to a hospital emergency department. Precedential cases in some jurisdictions have held that hospitals that maintain emergency facilities must assist a person who comes for treatment when that person has relied on some

11. *Id.* at 536.

12. *See* Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901). The American Medical Association (AMA) recognizes the physician's right to choose his patients. In an emergency, however, a physician should render service to the best of his ability. CODE OF ETHICS § 5 (Americal Medical Ass'n).

13. Annotation, *Liability of Hospital for Refusal to Admit Or Treat Patient*, 35 A.L.R.3d 841 (1971).

14. 25 OKLA. STAT. § 1402 (Supp. 1985) provides: "It is a discriminatory practice for a person to deny an individual the full and equal enjoyment of the goods, services, facilities, privileges, advantages and accommodations of a place of public accommodation because of race, color, religion, sex, national origin, age or handicap."

15. "A place of public accommodation" is statutorily defined as "one which is, among other things, supported directly or indirectly by government funds." 25 OKLA. STAT. § 1401 (Supp. 1985).

16. A. SOUTHWICK, LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 184 (1978). *See* 63 OKLA. STAT. §§ 1-701 through 1-741 (1981) (regulations affecting general hospitals). The Oklahoma statutes do not appear to expressly place an affirmative duty on general hospitals to maintain an emergency room. However, the term "general hospital" means a hospital maintained for the purpose of providing hospital care in a broad category of illness and injury. *Id.* § 1-701(a)(1).

63 OKLA. STAT. § 330.71 (1981) recognizes the need for emergency medical care. This legislation, however, refers to emergency assistance given by hospital ancillary facilities or ambulance services prior to treatment by the regular hospital staff. The Hill-Burton Act (Hospital Survey and Construction Act of 1946) states that a public or a private hospital receiving Hill-Burton funds may not refuse emergency care or hospital admission on the basis of race, color, creed, or national origin. 42 U.S.C. § 291j (1982).

public representation by the hospital that emergency care is available.[17] These cases also suggest that the physician has a duty to examine the patient to determine whether an emergency exists.[18]

Once the hospital emergency staff begins to aid a patient, the duty to exercise reasonable care under the circumstances applies.[19] A doctor-patient relationship exists and the patient must be examined, his condition diagnosed by the treating physician, and follow-up care provided to avoid liability for abandonment.[20]

In an effort to induce physicians to render aid at accidents, many states have enacted "Good Samaritan" laws.[21] These laws all attempt to eliminate recovery of damages for ordinary negligence in the course of medical treatment at the scene of an accident. Relatively few courts have considered the application of such statutes to health care personnel within a hospital setting.[22] These courts have not extended the protection of Good Samaritan statutes to physicians who are members of the hospital's emergency panel.

Consent to Treatment

The general principles of consent to medical treatment are applicable in all situations involving medical care.[23] In cases of genuine emergency, such as

17. *See* Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961) (trial court concluded that even though a private hospital had no common law duty to treat any patient, the hospital did have a duty to give treatment in an emergency case if the patient had relied upon a well-established custom of the hospital to render aid in such a case). *See also* Guerrero v. Copper Queen Hosp., 22 Ariz. App. 611, 529 P.2d 1205 (1974) (private hospital which held out its emergency treatment facilities to the community could not refuse to aid patients requesting care), *vacated* 112 Ariz. 104, 537 P.2d 1329 (1975).

18. *See* cases cited *supra* note 17.

19. *See* Shilkret v. Annapolis Emer. Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975) (advances in the profession, availability of special facilities, etc., will be taken into account). The standard to be applied in an emergency is that degree of skill, care, and knowledge that the average practitioner would use under the circumstances imposed by the emergency. In Oklahoma, the hospital "must exercise such care and caution for the patient's safety as the patient's mental and physical condition, as known or should be known to the hospital authorities and employees may require." Tulsa Hosp. Assoc. v. Juby, 73 Okla. 243, 175 P. 519, 523 (1918). *See also* Annotation, *Locality Rule as Governing Hospital's Standard of Care to Patient and Expert's Competency to Testify Thereto*, 36 A.L.R.3d 440 (1971).

20. Since a physician has no duty to treat, commencement of actual treatment imposes a contract and a duty upon the physician to follow through. *See* Lyons v. Grether, 218 Va. 630, 239 S.E.2d 103 (1977).

21. 76 OKLA. STAT. §§ 5-5.7 (1981). The Oklahoma "Good Samaritan" Act exempts those who give aid under emergency circumstances "except for committing gross negligence or willful or wanton wrongs in rendering the emergency care." *Id.* § 5(c)(2).

22. *See* McKenna v. Cedars of Lebanon Hosp., 93 Cal. App. 3d 282, 155 Cal. Rptr. 631 (1979) (extended the statute to a resident who was not a member of the emergency team). *But cf.* Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975) (held that the medical expertise of a hospital is assumed and the Good Samaritan statute did not apply).

23. Smith v. Reisig, 686 P.2d 285 (Okla. 1984) (failure to disclose alternative treatments gave rise to liability under informed consent); Masquat v. MacGuire, 638 P.2d 1105 (Okla. 1981) (failure to inform patient of different methods of treatment did not vitiate consent); Scott v. Bradford, 606 P.2d 554 (Okla. 1980) (Oklahoma officially adopted the doctrine of informed consent).

when a patient is unconscious or sufficiently ill to be unable to comprehend, the physician may give necessary treatment without attempting to explain or to inform the patient of risks.[24] This so-called "emergency doctrine" is limited to situations that require immediate action for the preservation of life or health of a patient.

Hospital Liability in the Emergency Room Context: Theories of Recovery

Historically, courts have perceived hospitals as being much like innkeepers, but providing quarters in which patients could receive care and treatment from a privately selected physician.[25] Moreover, the courts emphasized that hospitals, unlike physicians, were not licensed to practice and, therefore, could not be held liable for deficiencies in medical treatment. Determination of a hospital's liability was limited to an evaluation of the facilities and the support staff.

The courts' rationale for refusing to impose liability on hospitals was that a hospital has no control over medical decision making. Physicians, because of their skill and training in a highly technical field, were not properly subject to the control of hospital lay boards. Therefore, hospitals were deemed responsible for only the administrative aspects of treatment, even where physicians were employees.[26] There has been a steady erosion of this narrow view of hospitals' liability, and courts have begun to broaden the scope of hospitals' responsibility for the quality of medical care.

Corporate Liability: The Hospital's Duty to Monitor Physician Activities

As governmental and charitable immunity for hospitals begins to diminish, hospitals' negligence liability is increasing.[27] An evolving view of hospital

24. *E.g.*, Canterbury v. Spence, 464 F.2d 272 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). This is the classic case that explains the informed consent doctrine. The court recognized two exceptions—emergency treatment and therapeutic privilege (disclosure might harm the patient). 464 F.2d at 788-89. In Oklahoma the Good Samaritan Act provides that exemption from liability will not attach if the adult victim is conscious and capable of giving or refusing his consent; or if the victim's spouse, parent, or guardian can be reached in a reasonable time. 76 OKLA. STAT. § 5(a)(3) (1981). *See also* 59 OKLA. STAT. § 518 (1981) (no liability will attach to a licensed practitioner of a healing art for treatment of a minor without consent of a parent or guardian when such treatment was performed in an emergency and in good faith).

25. *Principles of Hospital Liability, supra* note 3, at 1, 3.

26. *See* Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429 (1973); Note, *Torts: The Expanding Liability of Hospitals*, 26 OKLA. L. REV. 441 (1973); Note, *Agency: Liability of a Hospital for Negligent Acts of a Physician-Employee*, 18 OKLA. L. REV. 77 (1965). Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

27. 41 C.J.S. *Hospitals* § 8 (1944). In the absence of statutory provisions, a hospital existing for governmental purposes is not liable for the negligence of its employees. Oklahoma has adopted the doctrine of sovereign immunity for the state, its political subdivisions, and all employees acting within the scope of employment, whether performing governmental or pro-

liability is that a hospital may be liable as a corporation to a patient for injuries suffered as the result of negligent treatment by a staff physician.[28] The hospital is said to have breached its independent duty of care to patients receiving treatment. Plaintiffs will generally sue both the hospital and the staff physician. Liability of hospitals based on a theory of corporate negligence has received limited acceptance but remains a source of continued litigation.

Darling v. Charleston Memorial Hospital[29] is the most frequently cited case that suggests a hospital owes a nondelegable duty to a patient who is treated by hospital emergency room staff. In *Darling*, an Illinois case, a hospital was held liable for injuries caused by the negligence of an independent staff physician. The plaintiff broke his leg while playing in a college football game. He was taken to the defendant hospital's emergency room where he was treated by a staff physician on emergency call.[30] An infection

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prietary functions. 51 OKLA. STAT. § 152.1 (Supp. 1985). *See* State *ex rel.* Dep't of Pub. Welfare v. Martin, 570 P.2d 623 (Okla. 1977) (operation of a children's hospital by the State Department of Public Welfare was a function of the state, and the doctrine of governmental immunity was applicable to bar action for damages for malpractice against hospital). *But see* 51 OKLA. STAT. § 153 (Supp. 1985) which provides:

> The state or a political subdivision shall be liable for loss resulting from its torts or the torts of its employees acting within the scope of their employment subject to the limitations and exceptions specified in the act, and only where the state or political subdivision, if a private person or entity, would be liable for money damages under the laws of this state.

See also Hershel v. University Hosp. Found., 610 P.2d 237 (Okla. 1980), *overruling* 570 P.2d 623 (Okla. 1977) (operation of state university hospital was a "proprietary function" exercised by the state for which the state was not immune from liability for tortious conduct arising therefrom). A private hospital that is not a charity is liable for damages arising from its negligence or from the negligence of its agents or servants. Charitable immunity has generally been abandoned in the United States. Courts now believe that such institutions should be liable for negligence just like other businesses. The courts also assume that such hospitals can purchase liability insurance. 41 C.J.S. *Hospitals* § 8 (1944).

28. Annotation, *Hospital's Liability for Negligence in Failing to Review or Supervise Treatment Given by Doctor, or to Require Consultation*, 12 A.L.R.4th 57 (1982); Darling v. Charleston Community Mem. Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) (hospital had a duty to protect patients from negligent care); Johnson v. Misericordia Community Hosp., 97 Wis. 2d 521, 294 N.W.2d 501 (1980), *aff'd*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981) (hospital liable for a physician's incompetency that could have been discovered had reasonable effort been made in evaluating his credentials). *See also* Fridena v. Evans, 127 Ariz. 516, 622 P.2d 463 (1980); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982) (hospitals have a continuing duty to ensure competence of those on its medical staff through review and supervision of physicians). *But see* Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984) (hospital's liability extends only to acts committed by a physician within the hospital).

29. 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

30. *Id.*, 211 N.E.2d at 258. In Oklahoma, hospital rules, regulations, and standards are established by statute. 63 OKLA. STAT. § 1-707 (1981). 63 OKLA. STAT. § 1-707(b) requires establishment of criteria for granting staff privileges. *See* Rogers v. Baptist Gen. Conv., 651 P.2d 672 (Okla. 1982). *See also* Warner v. Kiowa County Hosp. Auth., 551 P.2d 1179 (Okla. Ct. App. 1976) (one cannot operate a hospital without obtaining a license from the State Commis-

developed due to an improper application of the plaster cast. The plaintiff complained of severe pain and the nurses noted that the plaintiff's toes were swollen and dark. Eventually, the patient's leg had to be amputated.

The plaintiff brought an action against both the physician and the hospital, contending that the hospital was negligent because it failed to exercise adequate supervision over the physician; it allowed an unqualified physician to perform orthopedic surgery; and it failed to require consultation. In finding the hospital negligent, the trial court relied on evidence of the medical bylaws of the hospital and the Illinois licensing and accreditation standards. This evidence performed much the same function as custom in determining what constituted reasonable care under the circumstances. The Illinois Supreme Court upheld the lower court's decision and noted that the hospital had a duty to adequately monitor the physician's activities to ensure quality care for its patients.[31]

The *Darling* decision was one of the first to enunciate what has come to be called the doctrine of corporate responsibility.[32] This doctrine recognizes the existence of a duty owed directly by a hospital to a patient in connection with the care and treatment given to him. A hospital may be independently liable for failing to review or supervise treatment provided by a doctor or to require a consultation.

This expansion of hospital liability beyond the traditional theory of respondeat superior or the rules of charitable or governmental immunity is based on the changing role of modern hospitals. Hospitals now play an active role in supplying and supervising the purely medical care a patient receives. Independent physicians who are members of the hospital staff are subject to review and are required to comply with hospital standards. Consequently, even in the absence of an employee or agency relationship with the negligent doctor, the corporate negligence theory would impose direct liability on the hospital for failure to review or to supervise treatment.[33]

Premises Liability: The Hospital's Duty to a Patient/Invitee

Distinguishable from *Darling* corporate negligence situations, are the premises of liability actions under which a hospital has traditionally been

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sioner of Health and complying with rules, regulations, and standards promulgated by the State Board of Health, which are designed to require at least minimum professional proficiency in terms of patient care and protection).

In many instances, minimum national standards for hospital accreditation are set by the Joint Commission on Accreditation of Hospitals. The Commission enforces standards in hospital care and administration. The Commission also recommends that medical staff committees regularly review the competence of staff members with the intention of instituting disciplinary action when necessary. W. WADLINGTON, J. WALTZ & R. DWORKIN, LAW AND MEDICINE 203 (1980).

31. Darling v. Charleston Community Mem. Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, 258 (1965).

32. *See* Annotation, *Hospital's Liability for Negligence in Failing to Review or Supervise Treatment Given by Doctor, or to Require Consultation,* 12 A.L.R.4th 57 (1982).

33. *Id.*

held liable. These actions differ from ordinary malpractice suits because they generally do not involve negligent treatment but are based on the hospital's liability as owner or operator of the facility. A patient who comes to the hospital for treatment occupies the legal status of an invitee. An invitee is one who is invited or permitted to enter and remain on the premises for the occupier's purpose.[34] The hospital owes a legal duty of care to the patient to make the premises safe from dangerous conditions or activities of which the hospital should reasonably be aware.

A hospital as a business entity is required to install equipment safely and to inspect equipment at regular intervals. A hospital is also responsible for maintaining the condition of the premises to prevent falls and other kinds of accidents. The care expected of a hospital in regard to its premises is determined by a patient's ability to look after himself, and hospital personnel are held to assume that persons of all levels of physical and emotional ability may use the facilities.[35]

Vicarious Liability: The Hospital as the Physician's Principal

Another theory upon which hospital liability for injuries occurring in the emergency room context can be based is that of vicarious liability. Vicarious liability is an umbrella doctrine that involves the responsibility of one who is not negligent for the negligence of another.[36] In these situations, the hospital as an institution may be held liable along with the person whose negligence gave rise to the cause of action.

Hospitals are generally liable under agency principles for negligence of their employees or other agents who cause injuries in the course of their duties under the theory of respondeat superior. Respondeat superior is a form of vicarious liability based on an employment or agency relationship.[37] Usually the doctrine will be available where an employment relationship exists. In order to recover, the plaintiff must show that the employee did not act beyond the scope of his employment and that the employer had the right to control the actions of the employee.[38]

The difficulty lies in defining "employment," and courts have identified a variety of factors, which, taken alone or jointly, solidify the relationship of employer/employee.[39] Another problem area is determining whether the

34. A. HOLDER, MEDICAL MALPRACTICE LAW 174 (1978).

35. *Id.* at 190. *See also* Perdue, *Direct Corporate Liability of Hospitals: A Modern Day Legal Concept of Liability for Injury Occurring in the Modern Day Hospital*, 24 S. TEX. L.J. 773 (1983).

36. 57 C.J.S. *Master/Servant* §§ 555-621 (1973).

37. *Id.* § 561.

38. *Id.* § 562.

39. Factors used to determine whether there exists an employment relationship will vary from case to case. The issue has turned on several factors. *See, e.g.*, Beeck v. Tucson Gen. Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (1972) (court found an employment relationship where hospital had legal right to control the performance of medical staff; where hospital provided space, equipment, and technical personnel; where hospital acted as billing agent for medical

employer has the right to control the employee's conduct. In an effort to avoid liability by placing the responsibility of supervision on the treating physician, hospitals may attempt to show that an employee has become a "borrowed servant" of the staff physician even though still employed by the hospital.[40]

Under the traditional theory of agency, for the hospital to be liable for a physician's malpractice in the emergency room, the hospital must have some control over the work performed. A physician's membership on the hospital's medical staff alone would not be sufficient to impose liability.[41] Contract physicians who take care of emergency patients at a hospital generally do not impose liability on the hospital if the hospital has no right to control the techniques used by the doctor.[42]

Whether the hospital has exercised sufficient control over the emergency room physician is a question of fact dependent on the circumstances of each case. There is, however, an emerging trend to expand the definition of employer/employee to include those independent contractors who would not traditionally be found to be in such a relationship. This is true despite the provisions in contracts between the hospital and contracting emergency room physicians designed to negate the hospital's control over treatment decisions.[43] Another manifestation of the trend to expand hospital liability is

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group; and where the patient had no control over selection of physician/radiologist); Overstreet v. Doctor's Hosp., 142 Ga. App. 895, 237 S.E.2d 213 (1977) (per contract provision, the hospital would exercise no control over emergency room); Hodges v. Doctors Hosp., 141 Ga. App. 649, 234 S.E.2d 116 (1977) (inquiry should focus on the hospital's right under a contract to control the time, manner, and method of the work that the physician performs).

40. *See* Lyons v. Grether, 218 Va. 630, 239 S.E.2d 103 (1977) (describing the doctrine of borrowed servant and wrestling with the idea of control). *See also* Turney v. Anspaugh, 581 P.2d 1301, 1306 (Okla. 1978) (an instruction suggesting that if the negligent nurses and technicians were acting for the mutual benefit of the defendant hospital and the defendant physician, then the plaintiff might have a cause of action against both defendants, fairly instructed the jury on the applicable law); Hull v. Enid Gen. Hosp. Found., 194 Okla. 446, 152 P.2d 693 (1944) (x-ray technicians employed by the hospital, but controlled by the doctor as to treatments, were determined to be loaned servants even though the hospital received part of the fee for the treatment); McCowen v. Sisters of Most Precious Blood of Enid, 208 Okla. 130, 253 P.2d 830 (1953) (it was error to direct a verdict for the hospital in a negligence case where an issue of fact existed concerning whether the staff surgeon exercised actual control of the operating room nurse).

41. M. MANCINI & A. GALE, *supra* note 7, at 211. *See also* Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957) (applying the principle of respondeat superior to the negligent acts of employed medical doctors and holding that the hospital was subject to liability for salaried doctors just as for other employees of the hospital).

42. Pogue v. Hosp. Auth. of DeKalb County, 120 Ga. App. 230, 170 S.E.2d 53 (1969) (after examining the contract between the hospital and the physician, the court determined that the agreement expressly designated the physician as an independent contractor).

43. Hollingsworth v. Georgia Osteopathic Hosp., 145 Ga. App. 870, 245 S.E.2d 60 (1978), *aff'd*, 242 Ga. 522, 250 S.E.2d 433 (1978) (appellate court held that an oral contract between a hospital and a physician for provision of emergency room services created a question of fact concerning whether the doctor was an employee or an independent contractor). *Cf.* Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977) (in applying an apparent agent theory, the court stressed the hospital's control over independently contracted emergency room physicians by vir-

to find ostensible agency where the facts do not support either a corporate negligence or employer/employee basis for holding the hospital responsible.

Ostensible Agency in the Emergency Room

Hospitals have a variety of methods to provide physician availability for the emergency room. One method is for the hospital to employ the physician; a second requires members of the hospital medical staff to work on a rotating basis. The most common method is a contractual agreement between the hospital and an independent physician group.[44] In the contractual arrangement, the physician group is generally paid a set sum for its administrative services; fees for professional services may be billed to the patient or to a third party. The hospital does not divest itself of the responsibility to provide quality care, no matter which of the emergency room staffing methods is utilized.

There are two types of agency relationships that may be used by a plaintiff to impose liability on a defendant hospital for the negligence of its staff: (a) actual agency and (b) apparent or ostensible agency.[45] An actual agency relationship is created as the result of an agreement between two parties that indicates that one of them (the principal) is willing for the other (the agent) to act for him subject to the principal's control.[46] For example, an actual agency relationship exists where a hospital and a physician enter into a contract where the agreement provides that the hospital will pay the physician a salary if the physician will treat the patients who seek emergency room care. In this case, since the physician is an actual agent of the hospital, the hospital can be held vicariously liable for the negligence of the physician/employee.

Entirely distinct from actual agency is an apparent or ostensible agency. Here, the principal manifests to a third party that another is his agent, even though the agent is not employed by the principal.[47] This form of agency ex-

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tue of admitting procedures, billing processes, and facility regulations); Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976) (appellate court held a hospital responsible for the negligence of a physician who operated its emergency room on a contract basis, notwithstanding the actual contract between physician and hospital designating the physician as an independent contractor).

44. *Admitting and Discharge*, in 1 HOSPITAL LAW MANUAL 32 (P. Lasky ed. 1980).

45. 3 AM. JUR. 2d, *Agency* §§ 73-77 (1986).

46. *Id.*

47. RESTATEMENT (SECOND) OF AGENCY §§ 1, 8 (1958). *See also id.* § 267 which provides:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

In Oklahoma, the ostensible agency doctrine has been applied in two recent cases: Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985) and Smith v. St. Francis Hosp., Inc., 676 P.2d 279 (Okla. Ct. App. 1983). The ostensible agency principle has also been applied in other jurisdictions. *See* Stewart v. Midani, 525 F. Supp. 843 (N.D. Ga. 1981); Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Vanaman v. Milford Mem. Hosp., Inc., 272 A.2d 718 (Del. 1970); Schagrin v. Wilmington Med. Center, Inc., 304 A.2d 61 (Del. Super. Ct. 1973); Irving v. Doc-

ists when the hospital does not directly employ the physicians who work in the emergency room but contracts with an outside company to provide the staff. If the patient seeks treatment primarily from the hospital emergency room staff and the hospital allows the patient to assume that the treating physician is acting on the hospital's behalf, an ostensible agency is created.

In order for the apparent agency doctrine to apply, the plaintiff must establish:

> (1) that the [principal] has manifested its consent to the exercise of such authority [to act as an agent] or has knowingly permitted the [agent] to assume the exercise of such authority: (2) that the [third person] knew of the facts and, acting in good faith, had a reason to believe and did believe that the [agent] possessed such authority; and (3) that the [third person], relying on such appearance of authority, has changed his position and will be injured or suffer loss if the act done by the agent does not bind the principal.[48]

A physician who has hospital staff privileges or the physician group under contract to manage the emergency department would not be considered employees of the hospital under the traditional approach to negligence actions. Courts have looked to the contract itself for evidence that the physician is an independent contractor. Other courts have determined that a hospital is not able to control the physician's independent medical judgment.[49] Some courts, however, are beginning to realize that physicians

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tors Hosp. of Lake Worth, Inc., 415 So. 2d 55 (Fla. Ct. App. 1982); Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985); Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972); Hardy v. Brantley, M.D., 471 So. 2d 358 (Miss. 1985); Kober v. Stewart, 148 Mont. 117, 417 P.2d 476 (1966); Arthur v. St. Peters Hosp., 169 N.J. Super. 575, 405 A.2d 443 (1979); Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976); Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980); Lundberg v. Bayview Hosp., 175 Ohio St. 133, 191 N.E.2d 821 (1963); Themins v. Emanuel Lutheran Charity Bd., 54 Or. App. 901, 637 P.2d 155 (1981); Capan v. Divine Providence Hosp., 287 Pa. Super. 364, 430 A.2d 647 (1980); Edmonds v. Chamberlain Mem. Hosp., 629 S.W.2d 28 (Tenn. App. 1981); Brownsville Med. Center v. Gracia, 704 S.W.2d 68 (Tex. Ct. App. 1985); Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978).

But see Trapp v. Cayson, 471 So. 2d 374 (Miss. 1985) (distinguished from Hardy v. Brantley, M.D., 471 So. 2d 358 (Miss. 1985) (staff physician on call and available to render radiologic services not ostensible agent of hospital where the only control the hospital has over physician is through credentials process and audits of the work of the department); Felice v. St. Agnes Hosp., 65 A.D.2d 388, 411 N.Y.S.2d 901 (1978) (distinguished an ostensible agency situation from one in which a patient retains his own private physician to treat him at the hospital). *See generally* Levin, *Hospital's Liability for Independent Emergency Room Service*, 22 SANTA CLARA L. REV. 791 (1982); Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability*, 11 WM. MITCHELL L. REV. 561 (1985); Note, *Medical Malpractice—Ostensible Agency and Corporate Negligence—Hospital Liability May be Based on Either Doctrine of Ostensible Agency or Doctrine of Corporate Negligence*, 17 ST. MARY'S L.J. 551 (1986).

48. 3 AM. JUR. 2d *Agency* § 80 (1986).

49. Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970) (where patient was examined by an

who work in the emergency room are employees of the hospitals, at least in the public mind. The physician is seen as an agent of the hospital even though he is an independent contractor. This theory for holding hospitals liable for the negligence of physicians or medical groups who run the emergency department is the apparent or ostensible agency concept.[50]

Apparent agency authority results from statements, conduct, or other manifestations of the hospital's consent whereby a patient is justified in believing that the emergency room physician is acting as an agent or employee.[51] The hospital is bound by the acts of the physician acting within the scope of his authority if the patient, in good faith, deals with the physician and relies on the skill of the physician.[52] A hospital may vest the emergency room physician with apparent authority by omission as well as commission.[53] If the hospital allows an ostensible agency relationship to be formed, the hospital has an affirmative duty to correct an erroneous impression.[54] Moreover, the doctrine of apparent authority may not be invoked by a patient who knows the limits and extent of a physician's authority.[55]

Some courts that have applied the ostensible agency doctrine to emergency room cases have held that it was a question for the jury to decide whether the hospital was holding out or representing the defendant physician to be an agent.[56] In *Adamski v. Tacoma General Hospital*, a patient treated in a hospital's emergency room brought a medical malpractice action against the hospital. The trial court granted the hospital's motion for summary judg-

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emergency room physician who failed to diagnose fractured vertabrae, the court dismissed the case against the hospital because the physician was an independent contractor by terms of an agreement). *See also* Overstreet v. Doctor's Hosp., 147 Ga. App. 895, 237 S.E.2d 213 (1977) (Court declined to find an emergency room physician to be an employee despite scheduling, billing, and other control features of the agreement between the physician and hospital; whether the hospital exercises control over the physician is a question of fact.); Pogue v. Hospital Auth., 120 Ga. App. 230, 170 S.E.2d 53 (1969).

50. 3 AM. JUR. 2d *Agency* §§ 78-81 (1986). *See, e.g.*, Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985); Smith v. St. Francis Hosp., 676 P.2d 279 (Okla. Ct. App. 1983). *But see* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1985); Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975).

51. 3 AM. JUR. 2d *Agency* §§ 78-81 (1986). *See* Grewe v. Mt. Clemens Gen. Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978) (physician was ostensible agent of the hospital because the patient did not have a patient/physician relationship with the physician independent of the hospital setting and no notice was given to the patient that the physician was an independent contractor).

52. 3 AM. JUR. 2d *Agency* § 81 (1986). The terms "apparent authority" and "agency by estoppel" are equivalent. Stated in terms of estoppel, the rule is that where a principal has, by his voluntary act, placed an agent in such a situation that a third person is justified in assuming that such agent has authority to perform a particular act and deals with the agent upon that assumption, the principal is estopped from denying the agent's authority. *Id.*

53. *Id.*

54. *Id.* § 79.

55. *Id.*

56. Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970 (1978).

ment on grounds that the treating physician was an independent contractor and not a paid employee of the hospital.[57]

On appeal, the Washington Court of Appeals reversed and remanded to the trial court because a material issue of fact existed as to whether the emergency room physician who treated the patient was an agent of the hospital.[58] The court, in reaching its decision, stated that:

> [A] jury could find that Tacoma General held itself out as providing emergency care service to the public. A jury could find that the plaintiff reasonably believed Dr. Tsoi was employed by the Hospital to deliver that emergency room service. It appears plaintiff was not advised to the contrary and, in fact, he believed he was being treated by the Hospital's agent.[59]

In *Arthur v. St. Peter's Hospital*,[60] the Superior Court of New Jersey took judicial notice of the fact that "generally people who seek medical help through the emergency room facilities of modern-day hospitals are unaware of the status of the various professionals working there."[61] The court denied the defendant hospital's motion for summary judgment and cited several factors that might be considered in determining whether an ostensible agency existed: (1) whether the patient makes an independent selection of his physician; and (2) whether the patient is in some way put on notice of the independent status of the professionals with whom he comes into contact.[62]

The degree of the patient's involvement in the selection of his emergency room physician was seen as an important criterion in *Grewe v. Mt. Clemens General Hospital*.[63]

> In our view, the critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital

57. *Id.* In *Adamski*, the plaintiff injured his finger while playing baseball and later went to defendant hospital's emergency room for treatment. The physician in charge, Dr. Tsoi, treated and sutured the wound and told the plaintiff to consult with his personal physician for removal of the sutures in five to six days. The plaintiff was also given a hospital form that stated if plaintiff was unable to contact his personal physician he should feel free to contact the emergency department at the hospital. *Id.* at 972. When his finger became swollen the next day, plaintiff called the emergency room for advice and claimed he was told by the nurse that the pain and swelling were not unusual. The next day plaintiff contacted the hospital and was told the same thing and that he should see his personal physician. *Id.* at 972. Plaintiff tried to contact another physician who had treated him in the past but was referred to another hospital emergency room, where he was examined and referred to a private physician, Dr. Hirz. Dr. Hirz admitted the plaintiff to Lakewood Hospital and later surgically opened the injured finger and drained the wound. *Id.*

58. *Id.*

59. *Id.* at 979. *But see* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1984). A mere subjective assertion of reliance by a third party is not enough to create an ostensible agency because it must be judged within objective constraints. *Id.* at 674.

60. 169 N.J. Super. 575, 405 A.2d 443 (1979).

61. *Id.*, 405 A.2d at 447.

62. *Id.*

63. 404 Mich. 240, 273 N.W.2d 429 (1978).

> for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting.[64]

The court concluded that even in situations where medical personnel are independent contractors, the hospital can be held liable for the negligence of such personnel who are performing medical services ordinarily performed by the hospital.[65] The court stated that evidence presented at trial indicated that the plaintiff was seeking treatment from the hospital itself. There was no record of any preexisting patient-physician relationship with any of the medical personnel who treated the plaintiff. Consequently, the court upheld a jury verdict against defendant hospital based on the ostensible agency doctrine.

The Ohio Court of Appeals reversed a decision by the trial court in favor of a hospital and the city of Lakewood where a patient died after receiving treatment in the emergency room.[66] The court refused to allow a full-service hospital to "contractually insulate itself" from liability for acts of medical malpractice committed in its emergency room.[67] This was true even though the emergency room was operated by a third party based on a contractual agreement. The court stated that the hospital would be estopped to deny that physicians and other medical personnel on duty are its agents because the hospital purported to make emergency room treatment available to the public. This decision is in direct conflict with the traditional view that a hospital cannot be held liable for the negligent acts of independent contractor physicians.

In summary, the patient's reasonable expectations and reliance that emergency room professionals act on behalf of the hospital have influenced some courts to impose liability on hospitals for the negligence of independent contractors. The theory of apparent or ostensible agency creates vicarious liability where it appears that the hospital holds itself out as offering particular physician services such as emergency treatment even when the services are performed by physicians who are not paid by the hospital.

64. *Id.*, 273 N.W.2d at 433.

65. *Id.*, 273 N.W.2d at 435.

66. Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

67. *Id.*, 426 N.E.2d at 1190. *See also* Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (1976) (notwithstanding the actual contract between a physician and a hospital, the hospital exercised enough control over the operation of the emergency room to render it liable), *But see* Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979) (state statute requiring that every licensed general hospital provide a hospital emergency service not sufficiently broad to impose upon the hospital the duty to assume responsibility for the practice of medicine within an independently operated emergency room facility). *Id.*, 399 N.E.2d at 203.

The Ostensible or Apparent Agency Doctrine in Oklahoma

Two Oklahoma cases have considered the ostensible or apparent agency theory as a method of imputing liability to a hospital for the negligence of independent contractor/physicians in the emergency room setting. In the earlier case, the Oklahoma Court of Appeals seemed willing to concede that the apparent agency doctrine had some merit. In a later case, however, the Oklahoma Supreme Court adopted the language of the earlier case but reached a different result that turned on a preexisting doctor-patient relationship where the patient looked to her family physician for treatment of her problem.

Weldon v. Seminole Municipal Hospital

Weldon involved an appeal from a district court decision granting a hospital's motion for summary judgment in a negligence action against the hospital and two doctors.[68] Jennifer Weldon, a minor, and her father, Leonard Weldon, sought damages for injuries that resulted from the alleged negligence of Dr. C. H. Price, Dr. Julian E. Wood, and Seminole Municipal Hospital in the attempted removal of a bead from Jennifer's ear.[69]

The Oklahoma Supreme Court, in a 5-4 decision, affirmed the district court's ruling and stated that the hospital could not be held liable on the facts under a theory of respondeat superior or ostensible agency for acts of an independent contractor/physician. Nor could the supreme court find evidence to support a finding that the hospital was liable for its own independent acts of negligence.[70]

The appellant was treated at Seminole Municipal Hospital for removal of a bead lodged in her ear. Aid was given by the Weldon's family physician, Dr. Price, in the emergency room of the hospital. Dr. Wood happened to walk by the emergency room and consulted with Dr. Price. Dr. Price tried, unsuccessfully, to remove the bead. He then transferred the appellant to a hospital in Oklahoma City where the bead was surgically removed.[71] The appellant sued the hospital, Dr. Price, and Dr. Wood to recover damages for the loss of hearing in appellant's right ear.[72]

The supreme court recognized that Oklahoma has joined those jurisdictions that have allowed an exception to the general rule that a hospital cannot be held liable for the negligent acts of an independent contractor. This exception was established in *Smith v. St. Francis Hospital* when the Oklahoma

68. Weldon v. Seminole Mun. Hosp., 703 P.2d 1059 (Okla. 1985).

69. *Id.* at 1060.

70. *Id.* at 1058.

71. *Id.* at 1059.

72. Appellant's brief set forth three propositions for the supreme court to consider. Proposition I asserted that the hospital's liability under a respondeat theory was a question of fact for the jury. Proposition II stated that the hospital could be held liable under the "ostensible agent" theory. Proposition III asserted that the hospital could be held liable for its own acts of negligence under a corporate negligence theory. Brief for Appellant, Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985).

Court of Appeals set out the ostensible agency or agency by estoppel exception based on the absence of a preexisting doctor-patient relationship where the patient looked to the hospital for treatment.[73]

The supreme court, however, restricted the application of this doctrine to exclude situations where a patient contacts his physician first and the patient has no reason to believe that the physician is acting on behalf of the hospital.

The *Smith* court concluded that where a hospital holds itself out as rendering emergency care and the patient reasonably relies on the hospital's representation, the treating physicians are acting on behalf of the hospital and the ostensible agency doctrine applies.[74] The critical factor was the absence of a preexisting relationship between the physician and the patient. In *Smith*, the patient looked solely to and relied upon the hospital for his treatment and had no reason to believe that the emergency room physicians were acting on their own behalf.[75]

Smith v. St. Francis Hospital

In *Smith* the Oklahoma Court of Appeals reversed a trial court's summary judgment in favor of a defendant hospital in a medical malpractice action.[76] Smith, the appellant, sought to recover damages for injuries allegedly sustained as the result of misdiagnosis of appendicitis by an emergency room physician. The appellant sued the hospital for the alleged negligence of the emergency room physicians based on an apparent agency theory. The hospital defended by renouncing any liability for the physicians based upon the theory that the doctors were not employees, servants, or independent contractors, but were employees of independent contractors.[77]

The appellant was taken to the emergency room of St. Francis Hospital for treatment of persistent pain in his stomach, groin, and leg. When appellant arrived at the emergency room, his medical history was taken and appellant's

73. 676 P.2d 279 (Okla. Ct. App. 1983). Oklahoma joined a growing list of jurisdictions that apply the apparent agency doctrine so that a hospital can be held liable for the negligence of physicians who are independent contractors. The test is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments, or merely viewed the hospital as the situs where his physicians would treat him for his problems. *Id.* at 282.

74. *Id.*

75. *Id.* at 283. *See also* Howard v. Park, 37 Mich. App. 496, 195 N.W.2d 39 (1972) (medical center was liable for the negligence of a surgeon, an independent contractor, for injuries sustained by plaintiff under the ostensible agent theory where the surgeon was referred to the plaintiff by the medical center, treatment took place at the center with the surgeon conducting himself as a member of the staff, and plaintiff was billed on medical center stationery with surgeon's name on it).

76. 676 P.2d 279 (Okla. Ct. App. 1983).

77. *Id.* at 281. The appellant contended that the trial court erred when it released the hospital from any responsibility for the alleged malpractice of its emergency room physicians. *Id.* at 280. The lower court ruled that as a matter of law the emergency room physicians were not acting as agents, servants, or employees of the hospital and dismissed the case against the hospital. On appeal, the order of the trial court granting summary judgment in favor of the hospital was reversed and remanded for further proceedings. *Id.*

mother advised hospital personnel that she believed her son had appendicitis. Smith was examined by a physician after approximately six hours and sent home.[78] When his condition worsened the next day, appellant returned to the emergency room where he was examined and sent home again. The appellant's appendix burst on the following day.[79]

In order to determine whether the facts would support a finding of an ostensible agency, the *Smith* court had to define the status of the physicians who treated the patient in relation to the hospital. The court resolved the issue by assuming, arguendo, that all the emergency personnel were independent contractors. The court then stated that even if the personnel were independent contractors, the hospital was estopped from denying responsibility for the negligence of its ostensible agents.[80] This was true because the patient "looked solely to and relied upon hospital for his treatment and was treated by medical personnel regulated and authorized by the hospital to render medical services in its emergency room, and because said personnel were placed by hospital in a position of apparent authority to act on behalf of hospital."[81]

78. *Id.* The appellant asserted that on his first trip to the emergency room he was examined by Dr. Johns, Dr. Lockhart, and several interns and that Dr. Lockhart diagnosed his condition as a spasmatic colon. *Id.*

79. *Id.* at 281. The hospital contended that Smith was examined by Dr. Lockhart on the second visit who confirmed his diagnosis of spasmatic colon. The appellant's mother stated at trial that her son was examined by a Dr. Burton. *Id.* at 280. On the third occasion Dr. Lockhart diagnosed the appellant as suffering from acute appendicitis. Drs. Tommey and Lockhart operated and the appellant remained in the hospital for ten days. *Id.* at 281.

80. *Id.* The court of appeals' finding with respect to Dr. Johns was that he was employed by Emergency Care, Inc. (ECI), which was under contract to staff the emergency room. The court looked to the terms of the contract to determine whether the hospital exercised control over these contract physicians so as to create a principal-agent relationship. The court concluded that ECI as well as the physicians were agents of the hospital. *Id.* The court never made a specific determination of the status of Dr. Lockhart, one of the physicians who examined and diagnosed the patient. The hospital admitted that Lockhart was a staff physician but attempted to avoid liability by claiming that the physician was a partner in Surgical Associates, Inc. (SAI). The court discounted this logic "in the absence of any consensual relationship or contractual privilege between hospital and SAI. Dr. Lockhart was a staff physician who happened to be a partner in SAI." *Id.* at 282. At this point in its decision, the court's analysis became unclear. The court, without declaring whether Dr. Lockhart was an independent contractor or an employee, began to discuss various theories of hospital liability with respect to the care provided by physicians. The result is a mixture of the corporate liability theory and the ostensible agency doctrine. *Id.* at 281-82. *See* Southwick, *Hospital Liability, Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 45-46 (1983) (no viable difference between doctrines of respondeat superior, ostensible agency, and corporate negligence).

81. *Smith*, 676 P.2d at 282. The Oklahoma Court of Appeals' decision recognized a limitation to the general rule that a hospital could not be held liable for the acts of independent contractor-physicians. The court stated: "It is reasonable that patients entering a hospital through its emergency room properly relied on the hospital's representation that the treating doctors and staff of the emergency room were acting on behalf of the hospital and not as individuals." *Id.* at 282. The court relied in part on the RESTATEMENT (SECOND) OF TORTS § 429 (1966), which provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the

Finally, the court of appeals adopted the test established in *Grewe v. Mt. Clements General Hospital*, which stated, "the critical question is whether the patient looked to the hospital for treatment or merely viewed the hospital as the situs where the physician would treat him for his problems."[82]

The *Smith* court was cognizant of the changing role of hospitals in our society. Hospitals serve as providers of medical care and treatment in addition to serving as a situs for treatment of patients by independent contractors. If a hospital does not take positive steps to put the patient on notice, the *Smith* decision would arguably allow a patient to assume that all medical personnel who treat him are acting on behalf of the hospital.

An Analysis of the Oklahoma Court Decisions

Weldon may be distinguished from *Smith* because there was a preexisting relationship and thus no basis for believing that the doctor was acting on behalf of the hospital.[83] Most courts still refuse to impose vicarious liability on a hospital where the patient contacts his personal physician and the doctor

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> employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

See also Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985) (hospital could be held liable on principles of ostensible agency for negligence of physicians who furnished treatment to patients in emergency room provided by the hospital and open to public, notwithstanding that physician was not actually employed by hospital); Grewe v. Mt. Clemens Gen. Hosp., 404 Mich. 240, 273 N.W.2d 429 (1978) (even where the physician is an independent contractor not subject to the hospital's control, that fact "is not of critical importance to the patient who is the ultimate victim of that physician's malpractice"); Cooper v. Curry, 92 N.M. 417, 589 P.2d 201 (1978) (rule of nonliability is out of tune with life about us, and a hospital should be liable for the malpractice of a surgeon whether he is an agent or an independent contractor; distinction between independent contractor and agent does not realistically reflect the symbiotic relationship between a hospital and its medical staff). *But see* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1985) (hospital patient's subjective assumption that emergency room doctor was an employee of the hospital was insufficient under Missouri law to create an ostensible agency).

82. 404 Mich. 240, 273 N.W.2d 429, 433 (1978). The *Grewe* test represents a departure from the traditional view that a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and only uses the hospital's facilities to treat his patients with whom he has a preexisting relationship. *See also* Smith v. St. Francis Hosp., Inc., 676 P.2d 279 (Okla. Ct. App. 1983) (hospital was estopped from denying responsibility for the negligence of its ostensible agents).

> Consequently, the hospital must be held accountable for the negligence, if any, of its authorized emergency room physicians regardless of whether or not he is an independent contractor by secret limitation contained in private contract between the hospital and doctor or by virtue of some other business relationship unknown to the patient and contrary to the hospital's conduct and representation.

Id. at 283.

83. Weldon v. Seminole Mun. Hosp., 709 P.2d 1058, 1060 (Okla. 1985). The state supreme court stated that unlike the patient in *Smith*, the patient in *Weldon* did have a preexisting relationship with the treating physician. Factors to establish this relationship were that Jennifer Weldon's mother called Dr. Price at home seeking help, the Weldons were not looking to the hospital to provide medical care, and the hospital merely provided its facilities. *Id.*

bills the patient directly.[84] Under the *Weldon* analysis, the general test will be whether the patient looked to the hospital for treatment or merely viewed the hospital as a place where his personal physician would treat him for his problem.[85]

In restricting the ostensible agency theory to instances where no preexisting relationship with the treating doctor exists, the Oklahoma Supreme Court would exclude some cases that should properly be ostensible agency cases. The critical question should be whether the patient reasonably believes that his doctor is acting as an agent of the hospital when he is working at the hospital.

If the patient in some vague way knows that the treating doctor is on the staff of the hospital and is on call at the emergency room, the patient might reasonably believe that his doctor is acting on behalf of the hospital. Even if the doctor bills the patient, the patient might think that the hospital has a relationship with his doctor that causes the doctor to act on the hospital's behalf.

If the *Weldon* court had followed the *Smith* analysis, it might have found that a question of fact existed as to whether an ostensible agency relationship had been created and that the issue should have been a matter for the jury's determination. The court could have found that the hospital held Dr. Price out as its agent by providing emergency room care and failing to advise the Weldons that Jennifer was not being treated by the hospital's agents.[86] The thrust of the ostensible agency doctrine requires the court to ask whether the hospital has cloaked the staff physician with the appearance of acting on the hospital's behalf so that the patient, in good faith, believes that the physician is an agent.[87] As stated in *Smith*, "[M]embers of the public who avail themselves of a hospital's emergency room services . . . have a right to expect competent medical treatment from the medical personnel."[88]

Dr. Price, the physician in *Weldon*, possessed staff privileges at the hospital and was furnished a rent-free medical office, a rent-free home for his personal use, three meals a day at no cost, and a laboratory.[89] Dr. Price may have treated all of his patients in the office provided by the hospital and probably submitted much of his laboratory work to the hospital facilities. Although the facts do not indicate how the hospital emergency room was staffed, it might be assumed, given its size and location, that Dr. Price worked in the emergency room on occasion. Because of his close association with the hospital, the Weldons may have been justified in believing that the physician was an agent of the hospital.

84. *See* Annotation, *Later Case Service*, 69 A.L.R.2d 305 (1984).

85. *Weldon*, 709 P.2d at 1060.

86. *See* Brief for Appellant, Weldon v. Seminole Mun. Hosp., 709 P.2d 1058 (Okla. 1985).

87. 3 AM. JUR. 2d *Agency* §§ 78-81 (1986). *But see* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1984) (mere fact that acts are done by one whom the injured party believes to be the hospital's servant is not sufficient to cause apparent master to be liable).

88. *Smith*, 676 P.2d at 282.

89. *Weldon*, 709 P.2d at 1060.

The Weldons were not obligated to inquire whether each person who assisted in the emergency room was a paid employee of the hospital.[90] Nor do the facts indicate that the hospital took any affirmative steps to inform the Weldons that Dr. Price was not its agent—no signs were posted, no written acknowledgment was advanced, no verbal statements were given.

Bing v. Thunig[91] stressed that hospitals are more than just places for physicians to bring their patients for treatment:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. . . . Certainly, the person who avails himself of hospital facilities expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.[92]

The supreme court in *Weldon* followed the rationale of the Washington Court of Appeals in adopting a formula to determine when to hold hospitals liable for the negligence of staff physicians.[93] *Adamski v. Tacoma General Hospital* established a two-part test: (1) whether the patient sought treatment primarily from the hospital, and (2) whether the hospital paid the doctor a salary.[94] The *Smith* court only questions whether the plaintiff, at the time of admission, looked to the hospital for treatment or simply saw the hospital as the place where his physician would treat him.[95] Further, the *Smith* analysis does not make payment of the physician's salary by the hospital a necessary requisite to impose liability.

The existence of an ostensible agency depends on whether the patient believes that the treating physician is an agent of the hospital. This belief is

90. *See* Stanhope v. Los Angeles College of Chiropractic, 54 Cal. App. 2d 141, 128 P.2d 705 (1942) (in finding an ostensible agency the court asserted that it could not be contended that respondent, when he was being carried from room to room suffering excruciating pain, should have to inquire whether the individual doctors were employees or independent contractors); Arthur v. St. Peter's Hosp., 169 N.J. Super. 575, 405 A.2d 443 (1979) (patients have the right to assume that emergency room physicians are employees of the hospital); Hill v. St. Clare's Hosp., 107 A.D.2d 557, 483 N.Y.S.2d 695 (1985) (where patient entered clinic for medical treatment and the clinic undertook to treat patient and furnished doctors, patient could properly assume that treating doctors and staff were acting on behalf of clinic).

91. 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

92. 143 N.E.2d at 8, 163 N.Y.S.2d at 11. RESTATEMENT (SECOND) OF AGENCY § 267 comment a (1958) states: "The mere fact that acts are done by one whom the injured party believes to be the defendant's servant is not sufficient to cause the apparent master to be liable. There must be such reliance upon the manifestation as exposes the plaintiff to the negligent conduct."

93. Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 579 P.2d 970, 975 (1978). This formula was first applied in Brown v. La Societe Francaise de Bienfaisance Mutuelle, 138 Cal. 475, 71 P. 516 (1903).

94. *Adamski*, 579 P.2d at 975.

95. Smith v. St. Francis Hosp., Inc., 676 P.2d 279, 281 (Okla. Ct. App. 1983).

generally formed when a hospital holds itself out to the public as providing emergency room services and the patient relies on the hospital to deliver care and treatment. Unless the hospital takes steps to put the patient on notice that the emergency room physician is not acting on behalf of the hospital, the patient is justified in believing the physician to be the hospital's agent. Logically then, whether the hospital paid the physician a salary should be irrelevant in finding an ostensible agency unless the patient knew the salary was being paid.

With respect to the plaintiff's corporate negligence theory in *Weldon*, the supreme court emphasized that the corporate negligence doctrine does not apply where the patient has not yet been admitted to the hospital.[96] The court did not discuss that factor in rejecting plaintiff's ostensible agency theory. But even where the plaintiff is not yet admitted, he could reasonably think that his doctor is working on behalf of the hospital if the doctor is making the decision whether to admit the patient.

The Unanswered Questions

One problem associated with applying the ostensible agency doctrine to hospital emergency room situations is proving patient reliance as a result of the hospital's holding out of the physician as its agent. Theoretically, in order to establish an ostensible agency, evidence must be introduced that shows the patient relied on the representation of the hospital. This evidence must also indicate that the patient changed his position and will suffer loss if the physician's acts do not bind the hospital.[97]

Neither the court of appeals in *Smith* nor the supreme court in *Weldon* reached this issue. The obvious difficulty associated with proving a patient's reliance is that the evidence will almost always center on the patient's own testimony. It is questionable how objective or truthful a patient will be if he has been permanently impaired as a result of the physician's alleged negligence.

Another question courts have difficulty in answering is how a hospital can intentionally represent to a patient that a physician is the hospital's agent, hence inducing patient reliance. The *Restatement (Second) of Agency* states that "the manifestation of a principal may be made to the community by

96. Weldon v. Seminole Mun. Hosp., 709 P.2d 1058, 1060 (Okla. 1985).

97. *See* Sztorc v. Northwest Hosp., 146 Ill. App. 3d 275, 496 N.E.2d 1200 (1986). The court considered whether patient reliance as a requirement for ostensible agency should be strictly enforced. The hospital tried to prove, through the plaintiff's own testimony, that she was unable to confirm that it would have made a difference in her decision to receive treatment if she had known whether the physicians were independent contractors or employees. The court held that a triable issue of fact existed and remanded to the trial court. 496 N.E.2d at 1202. *But see* Porter v. Sisters of St. Mary, 756 F.2d 669, 674 (8th Cir. 1984) (in order to prove reliance on the skill or care of an apparent agent, the patient would have to present evidence that his decision to allow a physician to perform surgery on him was made because he believed the doctor was an agent of the defendant hospital).

signs, by advertising, by authorizing the agent to state that he is authorized, or by continuously employing the agent."[98]

Because of the public's perception of the role of the hospital as a provider of emergency care, the hospital will probably have to take affirmative steps to inform the patient that the treating physician is an independent contractor for whom the hospital will assume no liability. Even then it is arguable that the ostensible agency doctrine might still apply under the test recognized by the Oklahoma Court of Appeals and the Oklahoma Supreme Court.

Conclusion

The use of emergency rooms in hospitals for emergent and nonemergent care has increased dramatically and shows no signs of abating. Because hospitals use a variety of staffing procedures for the emergency room, the application of principles of vicarious liability in this context will be a continuing source of litigation. In each case the court will have to analyze the facts to determine whether ostensible agency principles apply. These facts, however, should always be balanced with the hospital's responsibility to provide appropriate staff and facilities for emergency care where the hospital has undertaken to render such care to the public.

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98. *RESTATEMENT (SECOND) OF AGENCY* § 8 comment b (1958). *See also* Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985), where the court stated that the cases applying the ostensible agency doctrine do not require an express representation to the patient that the physician is an employee of the hospital nor do they require direct testimony as to reliance. A general representation is implied from the circumstances. *Id.* at 256.